

GENERAL INSTRUCTIONS

FOR COMPLETING THE QUESTIONNAIRES

As part of processing your request for and evaluation of your child, we ask you to complete the enclosed forms about your child and your family. We greatly appreciate your willingness to complete these forms. Your answers will give us a much better understanding of your child's behavior at home and your family circumstances.

1. All forms in this packet should be completed by the parent who has the primary responsibility for caring for this child. Where both parents reside with the child, this is to be the parent who spends the greatest amount of time with the child, or both parents together.
2. If your child is already taking medication for assistance with his/her behavior management or for any emotional difficulties, we must ask that you complete the questionnaires about your child's behavior based on how your child behaves when he/she is off this medication. In this way, we can get a clearer idea of the true nature of your child's difficulties. **Please check one of the blanks below:**

_____ My child currently does not take any medication for behavior problems. My answers are based on my child's behavior while he/she is **OFF** of medication.

_____ My child is currently taking medication for behavior problems. However, my answers are based on my child's behavior while he/she is **OFF** of this medication.

_____ My child is currently taking medication for behavior problems. My answers are based on my child's behavior while he/she is **ON** this medication. Please list medications.

When our office has received the entire packet, you will need to schedule an hour long appointment with Dr. Leslie Smith. Please contact Susan Pickard at (336) 802-2300 to schedule this appointment. We strongly recommend, due to the length of the appointment, not to bring any children to this visit.

CORNERSTONE
Pediatric Associates
 OF KERNERSVILLE

Leslie R. Smith, M.D.

DEVELOPMENTAL AND MEDICAL HISTORY

PREGNANCY AND DELIVERY

- A. Length of pregnancy (e.g. full term, 40 weeks, 32 weeks, etc.) _____
- B. Child's birth weight _____
- C. Did any of the following conditions occur during pregnancy/delivery?
- | | | |
|---|----|-----|
| <u>1. Forceps were used during delivery</u> | NO | YES |
| <u>2. Had a breech delivery</u> | NO | YES |
| <u>3. Took prescription medications</u> | NO | YES |
| If YES, name of medicine _____ | | |
| <u>4. Took illegal drugs</u> | NO | YES |
| <u>5. Used alcoholic beverage</u> | NO | YES |
| If YES, approximate number of drinks per week _____ | | |
- D. Did any of the following conditions affect your child during delivery or within the first days after birth?
- | | | |
|--|----|-----|
| <u>1. Injured during delivery</u> | NO | YES |
| <u>2. Cardiopulmonary distress during delivery</u> | NO | YES |
| <u>3. Delivered with cord around neck</u> | NO | YES |
| <u>4. Had trouble breathing following delivery</u> | NO | YES |
| <u>5. Needed oxygen</u> | NO | YES |
| <u>6. Was cyanotic, turned blue</u> | NO | YES |
| <u>7. Was jaundiced, turned yellow</u> | NO | YES |
| <u>8. Had an infection</u> | NO | YES |
| <u>9. Had seizures</u> | NO | YES |
| <u>10. Was given medications</u> | NO | YES |
| <u>11. Born with a congenital defect</u> | NO | YES |
| <u>12. Was in hospital more than seven days</u> | NO | YES |

INFANT HEALTH AND TEMPERAMENT

- A. During the first 12 months, was your child:
- | | | |
|--|----|-----|
| <u>1. Difficult to get to sleep</u> | NO | YES |
| <u>2. Sociable</u> | NO | YES |
| <u>3. Easy to comfort</u> | NO | YES |
| <u>4. Difficult to keep busy</u> | NO | YES |
| <u>5. Overactive, in constant motion</u> | NO | YES |
| <u>6. Very stubborn, challenging</u> | NO | YES |

EARLY DEVELOPMENTAL MILESTONES

A. At what approximate age did your child first accomplish the following:

1. Sitting without help _____
2. Walking alone, without assistance _____
3. Using single words (e.g., "Mama," "Dada," "ball," etc.) _____
4. Bladder training, day and night _____

HEALTH HISTORY

A. Date of child's last physical exam _____

B. At any time has your child had the following:

- | | | | |
|--|-------|------|---------|
| 1. Asthma | Never | Past | Present |
| 2. Allergies | Never | Past | Present |
| 3. Epilepsy or seizure disorder | Never | Past | Present |
| 4. Febrile seizures | Never | Past | Present |
| 5. Heart or blood pressure problems | Never | Past | Present |
| 6. Head injury with loss of consciousness | Never | Past | Present |
| 7. Lead poisoning | Never | Past | Present |
| 8. Speech or language problems | Never | Past | Present |
| 9. Chronic ear infections | Never | Past | Present |
| 10. Hearing difficulties | Never | Past | Present |
| 11. Eye or vision problems | Never | Past | Present |
| 12. Fine motor/handwriting problems | Never | Past | Present |
| 13. Gross motor difficulties, clumsiness | Never | Past | Present |
| 14. Appetite problems, overeating or undereating | Never | Past | Present |
| 15. Sleep problems, falling asleep, staying asleep | Never | Past | Present |
| 16. Other health difficulties | Never | Past | Present |
- Please describe _____

CHILD AND FAMILY INFORMATION

Child's Name _____ Birth Date _____ Age _____

Address _____
(street) (city) (state) (zip)

Home Phone () _____ Work Phone () _____ Dad / Mom
(Circle One)

Child's School _____ Teacher's Name _____

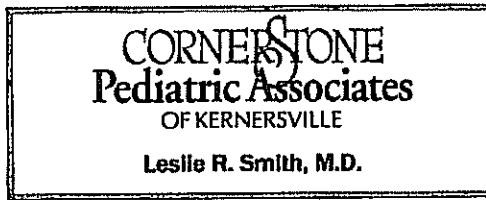
School Address _____
(street) (city) (state) (zip)

School Phone () _____ Child's Grade _____

Is this child in special education? YES NO If yes, what type? _____

Is this child adopted? YES NO If yes, at what age? _____

Are parents: Married? YES NO
Separated? YES NO
Divorced? YES NO



ADD PARENT QUESTIONNAIRE

Child's Name _____ Male or Female _____ Birth Date _____

Name of School _____ Current Grade _____

1. What are your child's favorite activities? _____
2. Are there things your child seems to do better than the average child? _____
3. How would you rate your child's current self-esteem? _____
4. At what age or grade did your child's problems begin to negatively affect them? _____
5. Quick overview of your child's **current** problems (check 1 box per line to indicate the level of dysfunction experienced).

	None	Mild	Moderate	Severe
Behavior at home.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Behavior at school.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Learning at school.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Homework.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

6. Has your child been treated with medication for any of the above? _____
7. Who referred you for this evaluation? (check all applicable answers below)

Staff of this Pediatric practice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Parent of patient of the Pediatric practice	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
LD/Resource Teacher	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Regular Teacher	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
School Principal	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Contact at CHADD	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other (specify) _____			

8. Previous workup by psychologic testing:

None	<input type="checkbox"/>	School Psychologist	<input type="checkbox"/>	Other Psychologist	<input type="checkbox"/>
		When? _____		When? _____	

9. Is school providing any special help? Yes No
 If yes, what? _____
 How often? _____

10. Overall, how would you rate your child's **current** school for trying to meet your child's special/individual needs? _____

11. Do you have any other major concerns? _____

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

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HE0350

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1-9: _____

Total number of questions scored 2 or 3 in questions 10-18: _____

Total Symptom Score for questions 1-18: _____

Total number of questions scored 2 or 3 in questions 19-26: _____

Total number of questions scored 2 or 3 in questions 27-40: _____

Total number of questions scored 2 or 3 in questions 41-47: _____

Total number of questions scored 4 or 5 in questions 48-55: _____

Average Performance Score: _____

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Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child was on medication was not on medication not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0302

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____
 Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance	Somewhat of a Problem				
	Excellent	Above Average	Average	Problem	Problematic
Academic Performance					
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Somewhat of a Problem				
	Excellent	Above Average	Average	Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____
 Mailing address: _____

 Fax number: _____

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Total number of questions scored 2 or 3 in questions 1–9: _____
 Total number of questions scored 2 or 3 in questions 10–18: _____
 Total Symptom Score for questions 1–18: _____
 Total number of questions scored 2 or 3 in questions 19–28: _____
 Total number of questions scored 2 or 3 in questions 29–35: _____
 Total number of questions scored 4 or 5 in questions 36–43: _____
 Average Performance Score: _____

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